

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011804	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2012
NAME OF PROVIDER OR SUPPLIER HEARTH AT SYCAMORE VILLAGE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: July 16 and 17, 2012</p> <p>Facility number: 011804 Provider number: 011804 AIM number: N/A</p> <p>Survey team: Christine Fodrea, RN TC Julie Wagoner, RN Shelley Reed, RN (7-17 only)</p> <p>Census bed type: Residential: 95 Total: 95</p> <p>Census payor type: Other: 95 Total: 95</p> <p>Sample: 8</p> <p>Hearth at Sycamore Village was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality review 7/18/12 by Suzanne Williams, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

812011

If continuation sheet 1 of 1